MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – The revised *Skilled Nursing Facility Consolidated Billing Web-Based Training Course* (October 2008), which provides general information about Skilled Nursing Facilities (SNF), SNF Consolidated Billing, and under "arrangement agreements" between SNFs and other providers or suppliers, is now available from the Centers for Medicare & Medicaid Services Medicare Learning Network. To access this course, visit http://www.cms.hhs.gov/MLNProducts/01_Overview.asp and select the "Web-Based Training Modules" link from the "Related Links Inside CMS" Section located at the bottom of this web page.

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Medicare Claims Processing Manual Clarifications for Skilled Nursing Facility (SNF) and Therapy Billing

Provider Types Affected

Skilled Nursing Facilities and other providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 6407, which includes clarifications to the *Medicare Claims Processing Manual* for Skilled Nursing Facility (SNF) and therapy billing. Be sure billing staff are aware of the clarifications.

Background

Change Request (CR) 6407 provides clarifications and updates to the Medicare Claims Processing Manual, Chapter 5 (Part B Outpatient Rehabilitation Billing), Section 20 (HCPCS Coding Requirements). These clarifications indicate that effective January 1, 2009, the new Current Procedural Terminology (CPT) code 95992 (*Canalith repositioning procedure(s) (eg Epley maneuver, Semont*

maneuver), per Day) is bundled under the Medicare Physician Fee Schedule (MPFS).

Regardless of whether CPT code 95992 is billed alone or in conjunction with another therapy code, separate Medicare payment is never made for this code. If billed alone, this code will be denied. On remittance advice notices for claims so denied, Medicare contractors will use group code CO and claim adjustment reason code 97 ("Payment is included in the allowance for another service/procedure."). Alternatively, reason code B15, which has the same intent, may also be used by your Medicare contractor.

In addition, CR 6407 provides clarifications and updates to the Medicare Claims Processing Manual (Pub 100-04), Chapter 6 (Skilled Nursing Facility (SNF) Inpatient Part A Billing), Section 40 (Special Inpatient Billing Instructions) to indicate that ***both full and partial benefits exhaust claims must be submitted by SNFs monthly.*** For benefits exhaust bills, an SNF must submit a benefits exhaust bill monthly for those patients who continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim; and
2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim.

Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period. Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

Note: Part B 22x (SNF inpatient part B) bill types must be submitted after the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech-language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not

eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (SNF inpatient part B) bill type.

Note: Unlike with benefits exhaust claims, Part B 22x bill types may be submitted prior to the submission of bill type 210 (SNF no-payment ***bill type***).

Additional Information

The official instruction (CR 6407) issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1706CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.